

Which individual health insurance plan is best for you?

A Guide to assist consumers with shopping for individual health insurance

Shopping for 2019

Health insurance can be confusing, and sometimes it's hard for consumers to choose between all of the plans that are available. There are many options. Which is best for you? This Guide will ask you **QUESTIONS**. Your answers will help you select the best plan for you.

First, let's determine **WHERE** you should shop.

There are two ways to buy individual coverage:

- Through the Marketplace (www.healthcare.gov); or
- Off the Marketplace (directly from an insurance company or with the assistance of an agent)

QUESTION Is your income below 400% of the Federal Poverty Level (FPL)? Not sure?

- Here is a link to the guidelines for 2018. The guidelines are updated each year. <https://aspe.hhs.gov/poverty-guidelines> Since you need to know the 400% level, multiply the amount of the poverty level shown for your family size (persons in household) by 4. Example: For a family of three the 2018 poverty level is \$25,100. 400% FPL for that family is \$25,100 x 4 or \$100,400.

Income below 400% FPL

- Apply through the **Marketplace**. You may qualify for tax credit that will lower your monthly premium. The amount of reduction to premium depends on your income. The Marketplace will determine if you qualify for a tax credit and the amount of the credit. Information regarding the Marketplace and the plans available through the Marketplace is available on www.healthcare.gov or you can call 1-800-318-2596.

Exception: If you are not lawfully present in the United States you cannot qualify for a tax credit and you cannot buy through the Marketplace. But, you can buy off the Marketplace.

Income exceeds 400% FPL

- Apply **Off the Marketplace** or through the **Marketplace – your choice**. Since your income is too high to qualify for a tax credit, you can buy “Off the Marketplace” which means you can deal directly with your agent or the insurance company. More insurance companies offer plans off the Marketplace and some companies that sell through the Marketplace offer some plans that are available only off the Marketplace, so shopping off the Marketplace means you will have more choices. Information regarding individual plans available for sale can be found at: www.dobi.nj.gov/ihc/. From the Shopping for Insurance page on this website, you can find the list of all of the insurance companies, how to contact them, and the 2019 rates for all plans. The calculator button makes it really easy to find the rates for your age and you can sort the plans by premium, by company or by metal level.

Now that you know where, let's consider **HOW** to shop.

NETWORKS

In 2019, **all** individual plans are either Exclusive Provider Organization (EPO) or Health Maintenance Organization (HMO) plans. EPO and HMO plans use networks of doctors, hospitals and other types of health care providers. Except for emergency care, EPO and HMO plans **only** cover services and supplies provided by **network providers**. This means you need to check out the network!

QUESTION Do you have *relationships with doctors and other providers* that are important to you?

- If yes, review the **networks** of the plans you are considering to be sure that your doctors and other providers participate in the network. This will allow you to maintain your relationship with the doctor or other providers. Be careful, a provider who says he or she “accepts” plans from an insurance company may not be in the network. Accepts is not the same as participates. Find out if your doctor **participates in the network by checking the provider directories of the plans you are considering**. These can be found on the carrier’s websites and are plan specific – so be sure to select the plan name and plan type you are thinking about purchasing in order to get accurate results. Or, call the carrier directly to check on network status. Also, be sure to check that both your provider and the office location that you use are listed in the provider directory. Some doctors practice at multiple locations and not all locations may be participating.
- If no, it is still wise to review the networks of the plans you are considering. You’ll want to find a doctor! Some networks of providers may be more convenient for you, depending on where you live and your transportation options.

Note: If it is medically necessary for you to use a doctor or other provider that does not participate in any plan you may want to request an “in plan exception.” Refer to the information later in this Guide.

Tiers

Some of the 2019 plans use tiers. This means some of the network providers are designated as tier 1 and other network providers are designated as tier 2. Although both tier 1 and tier 2 providers are in the network, you generally pay less out-of-pocket for services when you use a tier 1 provider than you would pay if you use a tier 2 provider.

QUESTION If you are looking at a plan that has tiers, how *likely are you to use providers in the lowest cost tier?*

- While there are great cost savings associated with the use of tier 1 providers, they are only realized if you actually **use** tier 1 providers. Check the networks for tiers and where your providers are in those tiers!

PLAN DESIGN

Cost Sharing

Cost sharing refers to what you have to pay when you use services covered under the plan. Many individual plans use a combination of copayments, deductible and coinsurance. For any given service covered under a plan, you may be required to pay just a copayment, or deductible and copayment, or just deductible, or deductible and coinsurance or just coinsurance. So you are not overwhelmed trying to figure out how cost sharing works for all services under the plan, let’s focus on **your** typical or expected use of services to try and estimate your out-of-pocket costs that you will have to pay *in addition* to your monthly premium.

Think of what your typical year looks like in terms of your utilization of health care.

QUESTION How many times do you go to your primary care provider (PCP) for sick visits?

- Now, check out the cost sharing for PCP visits under the plan you are considering. Wellness or preventive visits have no cost sharing. Be sure to look at the cost sharing for non-preventive services. Would you have to pay a copayment for each visit? Does the deductible apply? Does coinsurance apply? Try to estimate the total cost for your anticipated PCP visits under each plan you are considering. Some examples might help.
 - If the plan requires a \$25 copay for each PCP visit, and you estimate four PCP visits per year, you will have to pay \$100 out-of-pocket during the year for those PCP visits.
 - If the plan applies a \$2,500 deductible followed by 20% coinsurance to PCP visits, and you have not yet met your deductible, you will have to pay the allowed charge (the negotiated rate agreed to between the PCP and the carrier) in full until you satisfy the deductible. If the allowed charge for a PCP visit is \$100, you would pay \$400 for those four PCP visits. Of course, if the deductible has already been satisfied with other services before you visit the PCP, the 20% coinsurance would apply to the PCP visits which means you would be responsible for \$20 for each PCP visit.

QUESTION Do you visit specialists? If yes, how many visits per year?

- Would you have to pay a copayment for each visit? Does the deductible apply? Does coinsurance apply? For example, if you have a medical condition that requires you to see specialists 6 times a year, take a look at how the plans cover those specialist services. Some examples might help.
 - If one plan requires a \$50 copay per visit, you can assume you will have to spend \$300 out-of-pocket during the year for those visits.
 - If another plan applies a \$2,500 deductible and 20% coinsurance to the specialist visits, it is safest to assume that the allowed charges for those 6 visits would have to be paid by you out-of-pocket during the year and would be applied towards the deductible. For example, if you have not yet met your deductible, you will have to pay the allowed charge (the negotiated rate agreed to between the specialist and the carrier) in full until you satisfy the deductible. If the allowed charge for a specialist visit is \$200, you would pay \$1200 for those six specialist visits. Of course, if the deductible has already been satisfied with other services before you visit the specialist, the 20% coinsurance would apply to the specialist visits which means you would be responsible for \$40 for each specialist visit.

QUESTION Do you use other kinds of providers such as a physical therapist? If yes, how often?

- Again, check out the cost sharing that applies to those types of services. Referencing the examples above, try to estimate what it would cost you in a typical year.

QUESTION What about prescription drugs? Are you taking generics or brand name drugs?

- This one is harder to estimate because many plans have different costs sharing depending on whether the drug is considered to be “preferred” or “non-preferred.” You can call the company or visit the company’s website to find out whether your drugs are in the lowest cost tier or not. Some plans include a limit on how much you have to pay for each prescription. If you take a lot of drugs that kind of feature could help you.

QUESTION Now think about the coming year. Are you waiting to schedule surgery, maybe a knee replacement or some other type of surgery?

- If you are planning a knee replacement next year, you will want to consider how the plans cover specialist physician and facility charges for surgery as well as how they cover charges for physical therapy, and your estimated out-of-pocket costs for these services.

Maximum Out-of-Pocket (MOOP)

Good news! All plans have a MOOP that caps your out-of-pocket costs for the year. Everything you pay as copayments, deductible and coinsurance during the year is added together. Once the sum of your copayments, deductible and coinsurance reaches the MOOP amount for the plan you select, you do not have to pay any more copayments, deductible or coinsurance for the rest of the year. In 2019 the per person MOOP cannot exceed \$7,900. When comparing plans, be sure to take note of the MOOP amount for each plan you are considering.

QUESTION Do you have a medical condition for which you expect to use lots of health care services this year? Do you take some very expensive prescription drugs?

- The MOOP is your safety net and will cap your out-of-pocket costs!

TOTAL COST OF COVERAGE

When you buy health insurance the total cost of coverage is made up of two costs: the premium you pay each month PLUS the cost sharing you pay out-of-pocket for the services you use.

Premiums

The premium is the fixed amount you must pay each month for the plan. Premiums vary from insurance company to insurance company and from plan to plan. Premiums are paid whether or not you use the services under a plan.

QUESTION How much can you afford to pay each month?

- If you are buying through the Marketplace and are eligible for a tax credit the monthly premium you must pay is reduced. If you are not eligible for the tax credit, you must be able to pay the premium yourself.

Cost Sharing

Now go back to your answers from the cost sharing section.

QUESTIONS What do you estimate your annual costs to be? Will you reach the MOOP?

Math Time!

Multiply the monthly premium by 12 to get the annual premium for the plan. To that annual premium add your estimated cost sharing for the year. If your estimate of out-of-pocket costs meets or exceeds the MOOP, simply add the MOOP to the annual premium.

Best Value

The best value will be the plan with the lowest **total** cost!!

But, remember that the plan network is very important, so don't forget to factor that into your decision making with consideration of cost!

IN-PLAN EXCEPTION

All of the individual plans offered by the various companies selling individual coverage in New Jersey in 2019 are network-only plans. Network-only plans cover services and supplies provided by doctors, facilities and other providers that are part of the plan's network. These plans DO NOT cover services and supplies from out of network providers except for emergency and urgent care. This means people covered under the plan will not be covered if they voluntarily elect to use the services of a doctor who is not in the plan's network. However, if they have an emergency and are taken to an out of network hospital and treated by an out of network physician, the emergency services will be covered. The plans are sold as Health Maintenance Organization (HMO) and Exclusive Provider Organization (EPO) plans. For the most part, the plans use networks that are New Jersey-only networks.

QUESTIONS What if you are currently covered under a group plan that lets you use out-of-state doctors and facilities? Or what if your current plan has out of network benefits? What if you are in the midst of treatment with a doctor that is located out-of-state? What are you supposed to do?

- The answer depends on **your** medical condition(s), **your** course of treatment, **your** medical history and the availability of providers in the new plan's network
- If none of the 2019 plans include your doctor or facility in the network, and since none of the plans have out of network benefits, it **may** be appropriate to request that the new company you select for 2019 provide coverage for your ongoing treatment using your current doctor and facility.
- Generally, it is appropriate to request an in-plan exception if the medical condition **cannot** be appropriately treated using providers that participate in the plan. Maybe the network just does not have the type of provider you need. Or, the network has the type of provider but the distance is unmanageable or the provider has no available appointments for months.
- Personal preference, regardless of the reasons for the preference, is **not** a good reason to expect that an in-plan exception will be allowed.
- Some examples might help. The first three address situations that could warrant an in-plan exception. The last two address situations where a request for an in-plan exception would probably fail.
 - Example 1: Suppose you have a medical condition for which there are a limited number of doctors with training and experience to treat the condition. If none of these doctors practice in New Jersey or participate in the new plan's network, you would want to request an in-plan exception.
 - Example 2: Suppose you have complicated medical conditions, have used local doctors in the past but they referred you to out of state doctors who really specialize in treating your types of conditions. You would want to request an in-plan exception.
 - Example 3: Suppose you have breast cancer and will be undergoing a mastectomy and reconstructive surgery. Your surgeon for the mastectomy is in the network but the

reconstructive surgeon your surgeon generally works with is not in the network. You would want to request an in-plan exception.

- Example 4: Suppose you have a medical condition that can be treated in New Jersey but you have chosen to use an out of state doctor and facility because of an excellent reputation. Or maybe someone you know used a certain doctor and had good outcomes. You can certainly request the in-plan exception. However, if your 2019 plan has network doctors who have the qualifications to provide medically necessary services and who are accepting new patients it will be difficult to build a case that it is clinically necessary to use an out of network provider.
- Example 5: Suppose you were diagnosed with a chronic condition such as diabetes several years ago and have to go to an endocrinologist every six months for checkups. Even though you have a several year history with the same endocrinologist, you would probably not be successful in obtaining an in-plan exception to continue with the same endocrinologist since all of the plans have endocrinologists in the network who could perform the same semi-annual exams and tests for your condition.
- A request for an “in-plan exception” would be made to the company you select for your 2019 plan. The request must explain why it is **medically necessary** to continue treating with the doctor and why transitioning care to a doctor in the new plan’s network would not allow you to continue clinically necessary care. Be sure to address care and treatment anticipated for 2019. It would be helpful to ask your treating doctors to provide a clinical justification for continued treatment by them. When asking your doctors to provide information ask them to prepare the same type of justification they generally provide for a utilization review request and to specifically explain why a change in providers would result in a deterioration of your health. Your request will be reviewed by the medical director at the new company you select for the 2019 plan.
- If the in-plan exception is approved you will be allowed to continue to treat with the doctor and your cost sharing will be at the network level. In other words, it will be as if you are using a provider that is in the network. Please note that the approval of the in-plan exception may be limited to a certain time period.
- If the request is denied you have a right to appeal the denial. The Appeal and Complaint Guide explains the process and is available at https://www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf.

Questions? If you have questions you can get help from the following:

- Insurance companies have employees who are ready to help you understand the plans they offer. Call and ask questions!
- Do you have an agent? Talk to him or her.
- The federal government has a call center set up to help consumers understand the **Marketplace**. The number is 1-800-318-2596.
- New Jersey has a call center with staff that can help you with questions for **off the Marketplace** offerings. The number is 1-609-292-7272 or 1-800-446-7467.

2019 Carrier List

Carrier Name	Web Address	Mailing Address	Telephone
AmeriHealth HMO Inc and AmeriHealth Insurance Company	www.amerihealth.com	259 Prospect Plains Road Bldg M Cranbury, NJ 08512	1-877-744-5422
Horizon Blue Cross Blue Shield of NJ and Horizon HealthCare of NJ	www.horizonblue.com	Three Penn Plaza East – PP09T Newark, NJ 07105-2200	1-800-224-1234
Oscar Garden State Insurance Corporation	www.hioscar.com	295 Lafayette St, New York NY 10012	1-844-672-2766
Oxford Health Insurance (NJ) Inc.	www.oxhp.com	7440 Woodland Drive Indianapolis, IN 46278	1-800-273-8115